Referral Check List

Child and Adolescent Psychiatric Partial Program
Bloomberg 12N
1800 Orleans St., Baltimore, MD 21287
Referrals: 410-955-0795 fax: 410-955-0798

Patient: ____________________________ DOB: ______________________

Referring Provider: To expedite the referral process and to ensure that adequate information if provided for insurance authorization, please fax the available/applicable information with the referral form:

_____ Intake History
_____ Physical Intake/Physical Exam
_____ Nursing History
_____ Primary Therapist Progress Notes
_____ Neuropsychological and or Psychological testing report
_____ Occupational Therapy records
_____ EKG
_____ Labs
_____ Interim Discharge Summary (if referred after an inpatient hospitalization).
_____ Most recent Court Order pertaining to guardianship if not in parent's care.

Referral Form

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1800 Orleans St., Baltimore, MD 21287
Referrals: 410-955-0795 fax: 410-955-0798

Referral Date: ___________________ Referral Agency: _________________
Referral made by: ________________ Phone: _________________________

Patient: ___________________________ DOB: _____________________
Address: ___________________________ Phone: ___________________
___________________________ Cell: _____________________
Social Security#: ___________________ Email: ___________@________
Gender: Male ☐ Female ☐ Race: _______ Ethnicity: ________
Residency: Baltimore City ☐ Baltimore County ☐ Other:____________________

Insurance: MA☐ Policy #: _____________________
Commercial ☐ Type:__________________
Policy #: _____________________ Group#:______________________
Policy Holder: ___________________ Employer: __________________
Uninsured ☐

Outpatient Psychiatrist Name and Phone:_______________________________
Outpatient Therapist Name and Phone:__________________________________
Pediatrician's Name and Phone:____
Other Healthcare provider: ____

Patient's living situation (check applicable):
☐ Both parents
☐ Parent and Stepparent
☐ One Parent
☐ Relative
☐ Foster Care
☐ Other
Name of Parent/Legal Guardian: ___________________ Phone: ___________________
Address of Legal Guardian if different than child's residence:
____
Does caregiver have transportation: ☐Yes ☐ No
Care giver treatment compliance: ☐ Good ☐ Fair ☐ Poor

Is parent/guardian able to participate in the program for a full two weeks or longer while the patient remains in treatment? (Planned vacations, religious observance, scheduled appointments etc.)
☐Yes ☐ No

Has parent/guardian agreed to participate at least 2x per week in partial family programming?
☐Yes ☐ No

Reason for referral/history of present illness (please include any suicidal or homicidal thoughts or actions, aggression, impulsive behaviors, and current issues)**:**
____
____
____
____
____
____

Concerning Behaviors/precipitating events (why are you referring to partial at this time?)**:**____
____

<u>Please identify past evaluations this child has received:</u>

☐ **ER evaluation at:** ____________ Dates: _____
☐ **Outpatient at:**____________ Dates:_____ Contact #:___________
☐ **Partial at:**______________ Dates:_____
☐ **Inpatient at:** ____________ Dates:_____

<u>Current/Past Medical Conditions:</u>

☐Seizures ☐Asthma ☐Diabetes ☐Closed head injury
☐Other ____

<u>Developmental History:</u>

Normal birth?
☐Yes ☐ No Describe:____________________________________
Developmental Delay?
☐Yes ☐ No Describe: ___________________________________
Autism?
☐Yes ☐ No
Speech Delay?
☐Yes ☐ No
Learning Disability?
☐Yes ☐ No Describe: ___________________________________
Pervasive Developmental Disorder (PDD)?
☐Yes ☐ No
Cognitive impairment?
☐Yes ☐ No IQ range (if known):__________________________

<u>Family History:</u>

☐ Suicide ☐Suicide attempt ☐Schizophrenia ☐Bipolar
☐Substance abuse ☐Depression ☐Other ____________________

Social History (including living situation, family members in the home, peer and community interactions)**:**____

____

____

Current Medications:

(Circle appropriate response)

Medication	Dose	Frequency	Response	Compliant?
			Good Fair Poor	Yes or No
			Good Fair Poor	Yes or No
			Good Fair Poor	Yes or No
			Good Fair Poor	Yes or No
			Good Fair Poor	Yes or No

Past Medications:

(Circle appropriate response)

Medication	Dose	Frequency	Response	Compliant?
			Good Fair Poor	Yes or No
			Good Fair Poor	Yes or No
			Good Fair Poor	Yes or No
			Good Fair Poor	Yes or No
			Good Fair Poor	Yes or No

Does the child have a history of abuse?:
Physical: ☐Yes ☐ No Describe:_________________________
Sexual: ☐Yes ☐ No Describe:_________________________
Emotional: ☐Yes ☐ No Describe:_________________________
Neglect: ☐Yes ☐ No Describe:_________________________

Is there an open CPS case? ☐Yes ☐ No
Has there been a past CPS case? ☐Yes ☐ No
(if yes, please describe and give name and contact info of CPS worker): ______________________

____

Does child have a substance abuse history? ☐Yes ☐ No
(if yes, please describe in detail indicating frequency and amount):__________________________

____

Legal History ☐Yes ☐ No
(if yes, please describe):____

____

School History:
Name of current school:____
Current Grade:_____________________
Does child have an IEP? ☐Yes ☐ No
History of past suspensions?: ☐Yes ☐ No
(if yes, describe):____

Expulsions?: □Yes □ No
(if yes, describe):____

Diagnosis: (Please use DSM 5/ICD-10 coding)
Axis I: ______________________
____
____
Axis II: ______________________
____
Axis III: ______________________
____
Axis IV: ______________________
Axis V: GAF:_______________ **Highest in past year:** _______________

As the referral source, what are you hoping will be addressed during a partial admission?
1.)____
2.)____
3.)____
4.)____